SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
Company Tracking Number:	*HH777*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

Filing at a Glance

Company: Principal Life Insurance Company

Product Name: Business Loan Protection Rider	SERFF Tr Num: PRLD-125812821	State: ArkansasLH
TOI: H11I Individual Health - Disability Income	SERFF Status: Closed	State Tr Num: 40446
Sub-TOI: H11I.005 Business Overhead Expense - Related to marketing with employer or association groups	Co Tr Num: HH777	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Author: R Grubb	Disposition Date: 10/07/2008
	Date Submitted: 10/06/2008	Disposition Status: Approved-Closed
Implementation Date Requested: 01/19/2009		Implementation Date:

State Filing Description:

General Information

Project Name: BLPR	Status of Filing in Domicile: Authorized
Project Number: HH777	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/07/2008	
State Status Changed: 10/07/2008	Deemer Date:

Corresponding Filing Tracking Number: HH777

Filing Description:

RE New Submission – Individual Disability Insurance Overhead Expense Insurance

HH 777 Business Loan Protection Rider

AA 1751-3 Disability Insurance Application

AA 1700-3 Disability Insurance Adjustment or Reinstatement App

SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
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TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

AA 2150-2 Overhead Expense Application Supplement

Enclosed for your review and approval are the forms listed above. These forms are new forms that, upon implementation, will replace the previously approved forms as noted on the list provided under the Supporting Documentation tab.

The new rider will be marketed to individuals, as well as to individuals of employer/employee groups and individual members of association groups, through licensed agents and brokers.

The submitted rider will be used with our previously approved Overhead Expense policy form HH 702 AR. Accompanying the forms is the Actuarial Certification for rider form HH 777, as well as an Addendum to Description of Policy, Issue Basis for the underlying policy form.

When the new rider is issued, the policy data page will display the following information:
HH 777 Business Loan Protection Rider
Effective Date: [January 1, 2009]
Business Loan Protection Termination Date: [December 31, 2039]
Business Loan Protection Maximum Monthly Benefit: [$xxx]
Business Loan Protection Elimination Period: [xxx]

Also enclosed are application forms which upon approval will be used with our disability insurance portfolio of products.

The forms enclosed for your review and approval are in final print form, subject only to minor modifications in format, paper size, stock, ink, border, company logo and adaptation to computer printing. In addition, depending on printer capabilities, the forms may be printed either simplex or duplex.

Company and Contact

Filing Contact Information

Rosemary Grubb, Senior Analyst grubb.rosemary@prinipal.com

SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
Company Tracking Number:	*HH777*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

711 High Street
Des Moines, IA 50392-0001
(800) 255-6603 [Phone]
(515) 235-5494[FAX]

Filing Company Information

Principal Life Insurance Company
711 High Street
Des Moines, IA 50392
(515) 246-7086 ext. [Phone]

CoCode: 61271
Group Code: 332
Group Name:
FEIN Number: 42-0127290

State of Domicile: Iowa
Company Type:
State ID Number:

SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
Company Tracking Number:	*HH777*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$130.00
Retaliatory?	No
Fee Explanation:	4 forms @ $20 each; 1 set of rates @ $50 = $130
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Principal Life Insurance Company	$130.00	10/06/2008	22949522

SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
Company Tracking Number:	*HH777*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/07/2008	10/07/2008

SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
Company Tracking Number:	*HH777*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

Disposition

Disposition Date: 10/07/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
Company Tracking Number:	*HH777*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Addendum to issue basis	Approved-Closed	Yes
Supporting Document	Forms being replaced list	Approved-Closed	Yes
Form	Business Loan Protection rider	Approved-Closed	Yes
Form	Disability Insurance Application	Approved-Closed	Yes
Form	Disability Insurance Adjustment or Reinstatement App	Approved-Closed	Yes
Form	Overhead Expense Application Supplement	Approved-Closed	Yes
Rate	Business Loan Protection Rider rates	Approved-Closed	No

SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
Company Tracking Number:	*HH777*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

Form Schedule

Lead Form Number: HH777

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	HH777	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Business Loan Protection rider	Initial		51	HH777.pdf
Approved-Closed	AA 1751-3	Application/Enrollment Form	Disability Insurance Application	Initial		47	AA1751-3.pdf
Approved-Closed	AA 1700-3	Application/Enrollment Form	Disability Insurance Adjustment or Reinstatement App	Initial		50	AA1700-3.pdf
Approved-Closed	AA 2150-2	Application/Enrollment Form	Overhead Expense Application Supplement	Initial		51	AA2150-2.pdf

BUSINESS LOAN PROTECTION RIDER

This rider is part of the policy. It is issued in consideration of the application and payment of the premiums for this rider and the policy to which it is attached. All definitions, provisions, exceptions, exclusions, limitations, and other terms of the policy apply to this rider unless specifically changed by this rider. The effective date of this rider is shown on the Data Page.

DEFINITIONS

CONTRACTUAL AGREEMENT – means a legal contract which states the terms of the agreement between You and the Lender. The issuance of this rider does not modify, change or alter the terms or conditions of the Contractual Agreement. We are not a party to the Contractual Agreement and have no liability for the terms and conditions under it.

DISABILITY/DISABLED – means Total Disability. If a Disability is caused by more than one Injury or Sickness, We will pay benefits under this rider as if the Disability was caused by only one Injury or Sickness.

BUSINESS LOAN PROTECTION ELIMINATION PERIOD – means the number of days from the start of a Continuous Disability for which no benefits under this rider will be paid. The Business Loan Protection Elimination Period is shown on the current Data Page.

BUSINESS LOAN PROTECTION MAXIMUM MONTHLY BENEFIT – means the monthly benefit amount provided by this rider and is shown on the current Data Page.

BUSINESS LOAN PROTECTION TERMINATION DATE – means the date as shown on the current Data Page.

LENDER – means the individual or entity that is party to the Contractual Agreement or its lawful successor, and is identified in the application.

BUSINESS LOAN PROTECTION BENEFIT SECTION

We will pay up to the Business Loan Protection Maximum Monthly Benefit for Your Continuous Disability that begins on or after the effective date of the rider and while the policy and this rider are in force and subject to the policy and rider provisions. Benefits start to accrue at the end of the Business Loan Protection Elimination Period. Benefits will continue during Your Continuous Disability but not beyond the Business Loan Protection Termination Date; however, if You are Disabled on the Business Loan Protection Termination Date the Business Loan Protection Maximum Monthly Benefit will not be paid for less than 6 months for Your Continuous Disability.

CONDITIONS OF PAYMENT

We will reimburse the amount of the monthly financial obligation as stated in the Contractual Agreement up to the Business Loan Protection Maximum Monthly Benefit shown on the current Data Page, for each month during your Continuous Disability, but not beyond the Business Loan Protection Termination Date, if:

1. The Contractual Agreement covered by this rider has not terminated and You are still responsible for the financial obligation in the Contractual Agreement; and
2. You satisfy the requirements of the Claim Information section and provide documentation of payment of the monthly financial obligation.

The financial obligation/expense under the Contractual Agreement covered by this rider is not a Covered Overhead Expense under the terms of the Policy and will not be paid as one.

We will refund any premium paid for this rider after the date the Contractual Agreement terminated, once evidence of the termination is received in our Office.

PAYMENT OF BENEFITS

If it is determined that benefits are payable, the first payment is due on the Contractual Agreement's payment due date after satisfaction of the Elimination Period. Benefits, including any refund of premium, will be paid to the Owner. A Loss Payee cannot be designated for the benefits payable under this rider.

If the Insured has coverage for the same Contractual Agreement with another company in effect at the time of Continuous Disability, the benefits of this rider will be adjusted to a proportion equal to the percentage this rider's benefit bears to the total amount of coverage. The total benefits provided by this rider and any other coverage in effect at the time of Continuous Disability will not exceed the total financial obligation outlined in the terms of the Contractual Agreement.

RIDER ADJUSTMENT OPTIONS

Subject to Our then current underwriting guidelines which may include requiring evidence of insurability, the Owner may request rider adjustments while the policy and this rider are in force with no premiums in default, and You are not Disabled under the policy or this rider. To request an adjustment, an application signed by the Owner is required. The application must also be signed by You if You are not the Owner and if evidence of insurability is required. An adjustment is effective on the Adjustment Date, subject to our prior approval and payment of the required premium.

The adjusted benefits apply to a Disability from a Sickness which first manifests itself or an Injury which occurs on or after the Adjustment Date and while this rider and policy are in force.

Any adjustment will change the information on the policy's Data Pages and new Data Pages will be provided.

ASSIGNMENT

We are not bound by an assignment until received in a written form acceptable to Us at Our Home Office. We assume no responsibility for any assignment's validity. An assignment does not change the ownership of the policy to which this rider is attached. Any assignment of the benefits of the policy does not apply to this rider. Any assignment of benefits for this rider is separate and distinct from any assignment of the benefits of the policy.

TERMINATION

This rider terminates on the first of:

1. The Business Loan Protection Termination Date; or
2. The date the Contractual Agreement covered by this rider terminated; or
3. The Owner's written request to terminate it; or
4. Your Age 65 Policy Anniversary; or
5. Termination of the policy of which it is a part.

Principal Life Insurance Company
Des Moines, Iowa 50392-0001

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Application – PART A

1. Personal Information about the Proposed Insured

Name (First, Middle, Last)			Gender ☐ Male ☐ Female	Date of Birth / /
Street Address			Social Security Number - -	State of Birth (Country, if other than U.S.)
City	State	Zip	Home Phone Number ( )	Work Phone Number ( )
Occupation/Duties			Driver's License Number	Driver's License State Issued

Have you smoked cigarettes or used a nicotine patch or gum within the past 12 months?..... ☐ Yes ☐ No
Are you a U.S. citizen? ☐ Yes ☐ No If no, submit Confidential Non-US Citizen Questionnaire.

2. Indicate Coverage(s) Applying For

☐ **Disability Income** (Complete Sections 3-7 and Part C)
☐ **Overhead Expense** (Complete Sections 4-7, Part C, and the *Overhead Expense* Application Supplement)
☐ **Disability Buy-Out** (Complete Sections 4-7, Part C, and the *Buy-Out* Application Supplement)
☐ **DI Retirement Security** (Complete Sections 4-7, Part C, and the *DI Retirement Security* Application Supplement)
☐ **Key Person Replacement** (Complete Sections 4-7, Part C, and the *Key Person* Application Supplement)

3. Disability Income

Monthly Benefit Amount: $ _____
Elimination Period: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day
Benefit Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
Your Occupation Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
SIS Monthly Benefit: $ _____ SIS Benefit Period must equal Base Benefit Period.
SIS Elimination Period: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day
Adaptable Income Benefits (AIB) **Note: AIBs program monthly benefits around other in-force coverage**
1st AIB Monthly Benefit: $ _____ from day _____ to day _____
2nd AIB Monthly Benefit: $ _____ from day _____ to day _____
SIS AIB Monthly Benefit: $ _____ from day _____ to day _____

Optional Benefit Riders

☐ Catastrophic Disability Benefit (CDB) Monthly Amount: $ _____
CDB Elimination Period: ☐ 90 day ☐ 180 day ☐ 365 day
CDB Benefit Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
☐ Cost of Living Adjustment: ☐ 3% max ☐ 6% max
☐ Extended Total Disability Benefit
Aggregate Benefit Factor: ☐ 50 ☐ 75 ☐ 100
☐ Recovery Benefit: ☐ 1 year ☐ 3 year
☐ Regular Occupation
☐ Residual Disability Benefit
☐ Short Term Residual Disability Benefit: ☐ 6 month ☐ 12 month
☐ Transitional Occupation Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
☐ Other _____

You ***MUST*** select **ONE** of the following:
☐ Benefit Update (BU) AND Future Benefit Increase (FBI)
☐ Benefit Update (BU) only
☐ Future Benefit Increase (FBI) only
☐ Neither BU or FBI

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Application – PART A

Proposed Insured _____ Policy Number (if known) _____

3. Disability Income (Continued)

Owner (if other than Proposed Insured) – (Please list owner below and sign Part C.)

Name _____ Address _____

City _____ State _____ Zip _____ Owner Taxpayer ID Number _____

Benefit Recipient (if other than Owner) for Disability Income Only

Name _____ Address _____

City _____ State _____ Zip _____

4. Premium Payer and Method of Payment

a. Premium paid by: ☐ Proposed Insured _____ % ☐ Employer _____ %

b. If your employer pays any part of the premium, is it reportable by you as taxable income?..... ☐ Yes ☐ No

c. Premium Mode: ☐ Annual ☐ Semi Annual* ☐ Quarterly* ☐ Monthly EFT*

* There is an additional charge for premium payment frequencies other than annual.

5. Other Disability Insurance

Do you have, are you applying for, or will you become eligible for in the next three years (based on a qualifying period of employment), any other Disability Insurance? ..... ☐ Yes ☐ No

If Yes, please list below any Disability Income (listing any Catastrophic or Lifetime Benefits separately), Group Disability, Association, State Disability, Retirement/Pension, Overhead Expense, Disability Buy-Out, Key-person, Salary Continuation or Short Term Contingency Disability Insurance. Also include any policies that include disability benefits provided under Accident or Sickness insurance, Pension, Retirement, Credit Insurance plans, or Loan Protection coverage.

Company	Policy No.	Type of Coverage	Benefit Amt. or % of Income	Elim. Period	Benefit Period	Ind. Pay (I) Emp. Pay (E)	Pending Yes	Pending No	Replacing Yes	Replacing No
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐

Replacement: By signing this application, I agree to terminate the insurance policy(s) that I indicated above as being replaced within 60 days of the acceptance of this policy. I understand that if I do not cancel or lapse the insurance policy(s), Principal Life Insurance Company has the right to rescind (terminate as if never issued) any policy issued as a result of this application.

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Application – PART A

Proposed Insured _____ Policy Number (if known) _____

6. Financial

a. **Unearned Income** – Includes capital gains, interest, dividends, net rental income, pensions, annuities, and alimony. Is unearned income greater than 10% of earned income, or $30,000? ☐ Yes ☐ No

If Yes, itemize: _____

b. **Net Worth** – Is net worth, excluding primary residence, greater than $6,000,000? ☐ Yes ☐ No

If Yes, itemize: _____

	Tax Year:	Current Year _____	Last Yr. _____	2 Yrs Ago _____
c.	**Earned Income** – Income as shown on Federal Income Tax Return:	Current YTD Income	Income Last Yr.	Income 2 Yrs Ago
c1.	Owner or Nonowner Employee's salary & bonus, (FormW-2). (less business expenses reported on IRS Form 2106)	$	$	$
c2.	Owner-Employee's share of after-tax corp profits or losses (after expenses) (minimum 20% active owner) (Form 1120 or 1120S)			
c3.	Sole Proprietor net income, after expenses (Form 1040, Schedule C)			
c4.	Share of Partnership or LLC net income, after expenses (Schedule K-1 or Form 1040, Schedule E)			
c5.	Pension plan or Profit-Sharing contributions made on your behalf, by a business you own			
c6.	Total Earned Income: Sum of (c1) thru (c5) for each year	$	$	$

If using Traditional application process, stop here and proceed to Part B (pages 4-7).

7. Medical Question

a. Within the last five years, have you had, been treated for, or been diagnosed as having a heart condition, chest pain, stroke, back or neck problem, psychological condition (including, but not limited to, counseling from a mental health or substance abuse provider, and/or psychotherapy), cancer, diabetes, alcohol abuse, or drug dependency? ☐ Yes ☐ No

If Yes, provide details in the Comments below, including dates and healthcare provider's name and address.

b. Current Height _____ Weight _____ Have you lost more than 10 lbs. in the last year? ☐ Yes ☐ No

Comments: _____

If using Teleapp, proceed to Part C (page 8).

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Application – PART C

Proposed Insured _____

Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application(s): I represent that all statements in this application(s) are true and complete and were correctly recorded before I signed my name below. I understand and agree that the statements in this application(s), including all of its parts, and statements by the Proposed Insured in any medical questionnaire(s) that becomes a part of this application(s), will be the basis of any insurance issued. I understand that misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Insurance Effective: I understand and agree that the Company shall incur no liability unless: (1) a policy issued on this application(s) has been received and accepted by the owner and the first premium paid; and (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is signed by me and the Proposed Insured (if different) and dated at delivery. If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy.

Limitation of Authority: I understand and agree that no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change, or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on this application(s) and on any medical questionnaire(s) that becomes a part of this application(s) may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).

☐ This application(s) is Cash on Delivery (C.O.D.); and no Conditional Receipt coverage is provided, or

☐ I have paid $ _____ for Disability Income/$ _____ for Overhead Expense/$ _____ for Disability Buy-Out/$ _____ for Key Person Replacement which is no less than one month's insurance advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:

☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

- Payroll Deduction Authorization Form
- Employer Pay Form
- Other form acceptable to the Company

(continued on next page)

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Application – PART C

Proposed Insured _____

(continued from previous page)

Agreement/Authorization to Obtain and Disclose Information

AUTHORIZATION: I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding the named Proposed Insured to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application(s) for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I have received a copy of the "Notice of Insurance Information Practices," which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application(s), or (2) the date of my policy. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

SIGNATURES (Please do not print name below. **Signatures, City, State and Date are required.**)

Proposed Insured **X**	Signed at: City	State	Date / /
Disability Income; Owner (If other than Proposed Insured) **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Overhead Expense; Owner (If other than Proposed Insured) **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Disability Buy-Out; Owner **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Key Person Replacement; Owner **X**	Title (Officer other than Proposed Insured)		Date / /
Agent/Broker/Licensed Representative **X**	License Number		Date / /
Co-signature by Resident Licensed Rep. (If applicable in your state) **X**	License Number		Date / /

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Application – PART C

Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application(s): I represent that all statements in this application(s) are true and complete and were correctly recorded before I signed my name below. I understand and agree that the statements in this application(s), including all of its parts, and statements by the Proposed Insured in any medical questionnaire(s) that becomes a part of this application(s), will be the basis of any insurance issued. I understand that misrepresentations could mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

When Insurance Effective: I understand and agree that the Company shall incur no liability unless: (1) a policy issued on this application(s) has been received and accepted by the owner and the first premium paid; and (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is signed by me and the Proposed Insured (if different) and dated at delivery. If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy.

Limitation of Authority: I understand and agree that no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change, or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on this application(s) and on any medical questionnaire(s) that becomes a part of this application(s) may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).

☐ This application(s) is Cash on Delivery (C.O.D.); and no Conditional Receipt coverage is provided, or

☐ I have paid $ _____ for Disability Income/$ _____ for Overhead Expense/$ _____ for Disability Buy-Out/$ _____ for Key Person Replacement which is no less than one month's insurance advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:

☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

- Payroll Deduction Authorization Form
- Employer Pay Form
- Other form acceptable to the Company

AUTHORIZATION: I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding the named Proposed Insured to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application(s) for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I have received a copy of the "Notice of Insurance Information Practices," which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application(s), or (2) the date of my policy. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Conditional Receipt

(In this Conditional Receipt (Receipt), "we", "us", "our", or "the Company" is Principal Life Insurance Company.)

Name of Proposed Insured

Advance payment of: (Disability Income) $ _____ (Overhead Expense) $ _____ (Disability Buy-Out) $ _____ (Key Person) $ _____

has been received this date as a premium deposit with the application(s) bearing the same date as this Receipt.

Agent/Broker/Licensed Representative

Date of Receipt ___ / ___ / _____

Authority:

This Receipt is not a "binder." No agent, broker, licensed representative, medical examiner, or telephone interviewer may accept risks, determine insurability, or bind the Company in any way. No agent, broker, or licensed representative may waive or change any terms of the Receipt, or of the policy(ies) applied for, or any other rights of the Company.

The agent, broker, or licensed representative has **NO AUTHORITY** to accept any premium or to issue this Receipt if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the agent, broker, or licensed representative, has authority to modify any provisions of this Receipt.**

Insurance Provided:

If all of the **Conditions Precedent** set forth in this Receipt are fulfilled exactly, insurance under this Receipt takes effect on the **Start Date**. The Start Date is the date upon which all of our initial application(s) requirements are completed. Our initial application(s) requirements consist of full completion and signing of the application(s) (Parts A and C, if using the telephone application(s) process; Parts A, B, & C, if using the paper application(s) process) and all necessary supplements, and any medical exams and tests required by our published rules.

The insurance provided by this Receipt shall be the lesser of the amount applied for on this application(s) or the amount set forth in the **LIMITATIONS** section of this Receipt, subject to all the **LIMITATIONS** set forth in this Receipt. Any insurance provided by this Receipt ends on the **Stop Date**, which is the **earliest** of:

(a) 75 days after the Start Date;

(b) the date we mail the premium payer a premium refund and the proposed owner a notice that we will not consider the application(s) on a prepaid basis;

(c) the date we mail the premium payer a premium refund and the proposed owner a notice that no policy(ies) will be issued on the application(s);

(d) the date a policy(ies) is presented to the proposed owner (whether or not accepted by the proposed owner).

This Receipt does not commit us to issue any policy(ies). However, in determining whether to issue a policy(ies) and on what terms, we will consider no changes in the Proposed Insured's health or insurability occurring between the Start Date and the Stop Date. We have until the actual delivery of the policy(ies) to make this determination. If an event giving rise to a claim occurs at any time before physical delivery and acceptance of a policy(ies) by the owner, the claim will be considered solely under this Receipt even if a policy(ies) is issued. If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

Conditions Precedent if a premium deposit is submitted with this application(s):

All the following conditions must be fulfilled exactly. Otherwise there is NO insurance under this Receipt and the Receipt is void:

1. On the Start Date, the Proposed Insured must be insurable, as determined by our underwriters under our underwriting guidelines then in effect. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
2. All statements of material fact are included in Part(s) A, B, and C of this application(s), any supplemental form(s), and medical questionnaire(s) that become part of the policy(ies) and such statements are correct, true, and complete.
3. The premium deposit must be at least one full month's premium for each policy(ies) applied for.
4. The premium deposit must be paid at the time this application(s) is signed, and this Receipt must be issued at the same time.
5. The premium deposit must be received in our Home Office and must be honored on first presentation for payment.

--CONTINUED--

Conditions Precedent if no premium deposit is submitted with this application(s):

All the following conditions must be fulfilled exactly. Otherwise there is NO insurance under this Receipt and the Receipt is void:

1. On the Start Date, the Proposed Insured must be insurable, as determined by our underwriters under our underwriting guidelines then in effect. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
2. All statements of material fact are included in Part(s) A, B, and C of this application(s), any supplemental form(s), and medical questionnaire(s) that become part of the policy(ies) and such statements are correct, true, and complete.
3. Documentation authorizing payment of premiums, which is acceptable to the Company, must be signed, dated, and submitted with this application(s), and this Receipt must be issued at the same time.
4. Documentation authorizing payment of premiums and acceptable to the Company must be received in our Home Office.

Limitations:

1. Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) including but not limited to all policy(ies) riders and endorsements.
2. No benefit is payable under this Receipt and this Receipt is void, if there is any incorrect, untrue, incomplete, or omitted statement of material fact in Part A, B, or C of the application(s), any supplemental form, or medical questionnaire(s) that becomes a part of the policy(ies). No knowledge of any fact on the part of any agent, broker, licensed representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).
3. **Disability Income, Catastrophic Disability Benefit, Overhead Expense, Business Loan Protection Benefit, Disability Buy-Out or Key Person Replacement –** For any claim that occurs at any time after the Start Date and before physical delivery and acceptance of a policy(ies) by the owner, any Disability Income, Catastrophic Disability Benefit, Overhead Expense, Business Loan Protection Benefit, Disability Buy-Out or Key Person maximum benefit payable will be the lesser of:
    - The amount of benefits applied for in the application(s);
    - The amount of benefits that would be offered subject to our then current underwriting guidelines and practices; or
    - $5,000 per month (Disability Benefit and Social Insurance Substitute Benefit); $5,000 per month (Overhead Expense Benefit); $5,000 per month (Business Loan Protection Benefit) $2,500 per month (Catastrophic Disability Benefit); $2,500 per month and $200,000 Lump Sum (Key Person Replacement Benefit); $500,000 (Disability Buy-Out Maximum Aggregate Benefit).

    The coverage available under the Conditional Receipt, such as the elimination period, the benefit period, the policy(ies), policy(ies) riders, and riders related to exclusions, limitations, modifications, or enhancements of coverage will be based on what we would have approved or offered to you subject to our then current underwriting guidelines and practices.

Premiums:

If a policy(ies) is issued from this application(s) bearing the same date as this Receipt, and the policy(ies) is accepted by the proposed owner, we will apply the premium deposit to the first premium due for such policy(ies). If no policy(ies) is put in force but a benefit is paid under this Receipt, we will keep the earned portion of the premium deposit and refund the balance, if any, to the premium payer. If no policy(ies) is put in force and no benefit is paid or if a policy(ies) is issued differently then applied for that results in a premium refund, the premium deposit or excess premium will be refunded to the premium payer. If this Receipt is issued for more than one type of insurance, the provisions of this paragraph shall apply separately with respect to each type.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PRINCIPAL LIFE INSURANCE COMPANY – DO NOT MAKE CHECKS PAYABLE TO THE AGENT/BROKER/LICENSED REP. OR LEAVE THE PAYEE BLANK.

Principal Financial Group

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Adjustment or Reinstatement Application – PART A

1. Personal Information about the Proposed Insured

Name (First, Middle, Last)			Gender ☐ Male ☐ Female	Date of Birth / /
Street Address			Social Security Number - -	State of Birth (Country, if other than U.S.)
City	State	Zip	Home Phone Number ( )	Work Phone Number ( )
Occupation/Duties			Driver's License Number	Driver's License State Issued

Have you smoked cigarettes or used a nicotine patch or gum within the past 12 months?..... ☐ Yes ☐ No

Are you a U.S. citizen? ☐ Yes ☐ No If no, submit Confidential Non-US Citizen Questionnaire.

2. Indicate the Purpose of This Application

☐ Adjustment only (answer Questions 3 - 8) ☐ Reinstatement only (answer Questions 4 - 8)

☐ Adjustment and Reinstatement (answer Questions 3 - 8) ☐ Non-Underwritten (answer Questions 3 - 4)

3. Description of Policy(s) After Adjustment

a. **Disability Income** **Policy Number** _____

Monthly Benefit Amount: $ _____

Elimination Period: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day

Benefit Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70

Your Occupation Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70

SIS Monthly Benefit: $ _____ SIS Benefit Period must equal Base Benefit Period.

SIS Elimination Period: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day

Adaptable Income Benefits (AIB) **Note: AIBs program monthly benefits around other in-force coverage**

1st AIB Monthly Benefit: $ _____ from day _____ to day _____

2nd AIB Monthly Benefit: $ _____ from day _____ to day _____

SIS AIB Monthly Benefit: $ _____ from day _____ to day _____

Other Benefit Riders (Please note: All benefit riders are **not** available for all policy series. Refer to the adjustment illustration for availability.) ☐ **I request no change to existing policy riders in force.**

Add	Delete	Change	Benefit Rider
☐	☐		Automatic Benefit Increase
☐	☐		Automatic Increase Option
☐	☐		Benefit Update
☐	☐	☐	Catastrophic Disability Benefit (CDB)$ _____ (total monthly amount) CDB Elimination Period: ☐ 90 day ☐ 180 day ☐ 365 day CDB Benefit Period: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
☐	☐	☐	Cost of Living Adjustment _____ %
☐	☐	☐	Extended Total Disability Benefit: ☐ 50 ☐ 75 ☐ 100
☐	☐		Future Benefit Increase
☐	☐		Partial Disability Benefit
	☐		Premium Refund Option
☐	☐	☐	Recovery Benefit: ☐ 1 year ☐ 3 year
☐	☐		Regular Occupation
☐	☐		Residual Disability Benefit
☐	☐		Return to Work
☐	☐	☐	Short Term Residual Disability Benefit: ☐ 6 month ☐ 12 month
☐	☐	☐	Transitional Occupation: ☐ 2 year ☐ 5 year ☐ to age 65 ☐ to age 67 ☐ to age 70
☐	☐	☐	Other _____

Proposed Insured _____ Policy Number (if known) _____

b. **Overhead Expense** – Complete Overhead Expense App Supplement **Policy Number** _____

Benefit Amount $ _____

Elimination Period ☐ 30 ☐ 60 day ☐ 90 day

Maximum Aggregate Benefit Factor ☐ 12 ☐ 18 ☐ 24

Other Benefit Riders (Please note: All benefit riders are **not** available for all policy series.)

☐ **I request no change to existing policy riders in force.**

Add	Delete	Change	Benefit Rider
☐	☐		Automatic Benefit Increase
☐	☐		Automatic Increase Option
☐	☐		Benefit Update
☐	☐		Residual Disability
☐	☐	☐	Business Loan Protection (BLP)
			BLP Monthly Benefit Amount $ _____ (round up to nearest dollar)
			BLP Elimination Period ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day
			BLP Termination Date: ____ / _____ (Loan payoff date or earlier selected date. Date must not exceed age 65 policy anniversary)
			MM YYYY
☐	☐	☐	Other _____

c. **Disability Buy-Out** – Complete Disability Buy-Out App Supplement **Policy Number** _____

Elimination Period _____ Lump Sum $ _____ and/or Monthly $ _____ Benefit Period _____

Other Benefit Riders

Add	Delete	Benefit
	☐	Employment in the Firm
☐	☐	Benefit Update

d. **DI Retirement Security** – Complete DI Retirement Security App Supplement **Policy Number** _____

Other Benefit Riders

Add	Delete	Benefit
☐	☐	Future Benefit Increase
☐	☐	Cost of Living Adjustment ☐ 3% max ☐ 6% max
	☐	Automatic Increase Option

e. **Key Person Replacement** – Complete Key Person Replacement App Supplement **Policy Number** _____

☐ Lump Sum benefit only (Complete Lump Sum section below)

☐ Combination method (Complete both Lump Sum and Monthly Payment sections below)

Lump Sum: Benefit Amount $ _____

Elimination Period ☐ 180 day ☐ 365 day ☐ 730 day

Monthly Payment: Benefit Amount $ _____

Elimination Period (must be less than lump sum elimination) ☐ 90 day ☐ 180 day

4. Brief Description of Adjustment, Reinstatement, or Special Instructions

_____

_____

_____

_____

Principal Financial Group

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Adjustment or Reinstatement Application – PART A

Proposed Insured _____ Policy Number (if known) _____

5. Other Disability Insurance

Do you have, are you applying for, or will you become eligible for in the next three years (based on a qualifying period of employment), any other Disability Insurance? ..... ☐ Yes ☐ No

If Yes, please list below any Disability Income (listing any Catastrophic or Lifetime Benefits separately), Group Disability, Association, State Disability, Retirement/Pension, Overhead Expense, Disability Buy-Out, Key-person, Salary Continuation or Short Term Contingency Disability Insurance. Also include any policies that include disability benefits provided under Accident or Sickness insurance, Pension, Retirement, Credit Insurance plans or any Loan Protection coverage.

Company	Policy No.	Type of Coverage	Benefit Amt. or % of Income	Elim. Period	Benefit Period	Ind. Pay (I) Emp. Pay (E)	Pending Yes	Pending No	Replacing Yes	Replacing No
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐
						☐ I ☐ E	☐	☐	☐	☐

Replacement: By signing this application, I agree to terminate the insurance policy(s) that I indicated above as being replaced within 60 days of the acceptance of this policy. I understand that if I do not cancel or lapse the insurance policy(s), Principal Life Insurance Company has the right to rescind (terminate as if never issued) any policy issued as a result of this application.

6. Premium Payer

a. Premium paid by: ☐ Proposed Insured _____ % ☐ Employer _____ %

b. If your employer pays any part of the premium, is it reportable by you as taxable income?..... ☐ Yes ☐ No

7. Financial

a. **Unearned Income** – Includes capital gains, interest, dividends, net rental income, pensions, annuities, and alimony. Is unearned income greater than 10% of earned income, or $30,000? ..... ☐ Yes ☐ No

If Yes, itemize: _____

b. **Net Worth** – Is net worth, excluding primary residence, greater than $6,000,000?..... ☐ Yes ☐ No

If Yes, itemize: _____

Tax Year:	Current Year _____	Last Yr. _____	2 Yrs Ago _____
c. **Earned Income** – Income as shown on Federal Income Tax Return:	Current YTD Income	Income Last Yr.	Income 2 Yrs Ago
c1. Owner or Nonowner Employee's salary & bonus, (FormW-2). (less business expenses reported on IRS Form 2106)	$ _____	$ _____	$ _____
c2. Owner-Employee's share of after-tax corp profits or losses (after expenses) (minimum 20% active owner) (Form 1120 or 1120S)	_____	_____	_____
c3. Sole Proprietor net income, after expenses (Form 1040, Schedule C)	_____	_____	_____
c4. Share of Partnership or LLC net income, after expenses (Schedule K-1 or Form 1040, Schedule E)	_____	_____	_____
c5. Pension plan or Profit-Sharing contributions made on your behalf, by a business you own	_____	_____	_____
c6. Total Earned Income: Sum of (c1) thru (c5) for each year	$ _____	$ _____	$ _____

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Adjustment or Reinstatement Application – PART A

Proposed Insured _____ Policy Number (if known) _____

If using Traditional application process, stop here and proceed to Part B (pages 4-7).

8. Medical Question

a. Within the last five years, have you had, been treated for, or been diagnosed as having a heart condition, chest pain, stroke, back or neck problem, psychological condition (including, but not limited to, counseling from a mental health or substance abuse provider, and/or psychotherapy), cancer, diabetes, alcohol abuse, or drug dependency? ..... ☐ Yes ☐ No

If Yes, provide details in the Comments below, including dates and healthcare provider's name and address.

b. Current Height _____ Weight _____ Have you lost more than 10 lbs. in the last year?..... ☐ Yes ☐ No

c. Are you actively working in your occupation at least 30 hours per week?..... ☐ Yes ☐ No

Comments: _____

If using Teleapp, proceed to Part C (page 8).

Principal Life Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance Adjustment or Reinstatement Application – PART C

Proposed Insured _____ Policy Number (if known) _____

Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application(s): I represent that all statements in this application(s) are true and complete and were correctly recorded before I signed my name below. I understand and agree that the statements in this application(s), including all of its parts, and statements by the Insured in any medical questionnaire(s) that becomes a part of this application(s), will be the basis for and form a part of the adjusted and/or reinstated policy. I also understand that misrepresentations could mean denial of an otherwise valid claim and rescission of the adjustment or reinstated policy during the contestable period.

For Adjustments Only: When Insurance Effective: I understand and agree that the Company shall incur no liability unless: (1) an Adjustment issued on this application(s) has been received and accepted by the owner and the first premium as required by the adjustment is paid; and, (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is signed by me and the Insured (if different) and dated at delivery. If these conditions are met, the adjustment is deemed effective on the date stated in the data pages.

☐ This application(s) is Cash on Delivery (C.O.D.); and no Conditional Receipt coverage is provided, or

☐ I have paid $ _____ for the adjusted Disability Income/$ _____ for the adjusted Overhead Expense/$ _____ for the adjusted Disability Buy-Out/$ _____ for the adjusted Key Person Replacement insurance, which is no less than one month's advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:

☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

- Payroll Deduction Authorization Form
- Employer Pay Form
- Other form acceptable to the Company

For Reinstatements Only: When Insurance Effective: I understand and agree that the Company shall incur no liability unless: (1) a policy reinstated on this application(s) has been received and accepted by the owner and three month's premium is paid; and, (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is signed by me and the Insured (if different) and dated at delivery. If these conditions are met, the reinstatement is deemed effective on the date of approval.

☐ This application(s) is Cash on Delivery (C.O.D.); and no Conditional Receipt coverage is provided, or

☐ I have paid $ _____ for reinstatement of this Disability Income/$ _____ for reinstatement of this Overhead Expense/$ _____ for reinstatement of this Disability Buy-Out/$ _____ for reinstatement of this Key Person insurance, which is no less than one month's advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:

☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

- Payroll Deduction Authorization Form
- Employer Pay Form
- Other form acceptable to the Company

Limitation of Authority: I understand and agree that no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change, or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on this application(s) and on any medical questionnaire(s) that becomes a part of this application(s) may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).

(continued on next page)

Principal Life
Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance
Adjustment or Reinstatement
Application – PART C

Proposed Insured _____ Policy Number (if known) _____

(continued from previous page)

PART C – Agreement/Authorization to Obtain and Disclose Information

AUTHORIZATION: I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding the named Proposed Insured to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application(s) for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I have received a copy of the "Notice of Insurance Information Practices," which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application(s), or (2) the date of my policy. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

SIGNATURES (Please do not print name below. **Signatures, City, State and Date are required.**)

Proposed Insured **X**	Signed at: City	State	Date / /
Disability Income; Owner (If other than Proposed Insured) **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Overhead Expense; Owner (If other than Proposed Insured) **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Disability Buy-Out; Owner **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Key Person Replacement; Owner **X**	Title (Officer other than Proposed Insured)		Date / /
Agent/Broker/Licensed Representative **X**	License Number		Date / /
Co-signature by Resident Licensed Rep. (If applicable in your state) **X**	License Number		Date / /

Principal Life
Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance
Adjustment or Reinstatement
Application – PART C

Proposed Insured _____ Policy Number (if known) _____

Agreement/Authorization to Obtain and Disclose Information.

("Company" means Principal Life Insurance Company)

AGREEMENT: Statements In Application(s): I represent that all statements in this application(s) are true and complete and were correctly recorded before I signed my name below. I understand and agree that the statements in this application(s), including all of its parts, and statements by the Insured in any medical questionnaire(s) that becomes a part of this application(s), will be the basis for and form a part of the adjusted and/or reinstated policy. I also understand that misrepresentations could mean denial of an otherwise valid claim and rescission of the adjustment or reinstated policy during the contestable period.

For Adjustments Only: When Insurance Effective: I understand and agree that the Company shall incur no liability unless: (1) an Adjustment issued on this application(s) has been received and accepted by the owner and the first premium as required by the adjustment is paid; and, (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is signed by me and the Insured (if different) and dated at delivery. If these conditions are met, the adjustment is deemed effective on the date stated in the data pages.

☐ This application(s) is Cash on Delivery (C.O.D.); and no Conditional Receipt coverage is provided, or

☐ I have paid $ _____ for the adjusted Disability Income/$ _____ for the adjusted Overhead Expense/$ _____ for the adjusted Disability Buy-Out/$ _____ for the adjusted Key Person Replacement insurance, which is no less than one month's advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:

☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

- Payroll Deduction Authorization Form
- Employer Pay Form
- Other form acceptable to the Company

For Reinstatements Only: When Insurance Effective: I understand and agree that the Company shall incur no liability unless: (1) a policy reinstated on this application(s) has been received and accepted by the owner and three month's premium is paid; and, (2) at the time of such receipt and payment, the person to be insured is actually in the state of health and insurability represented in this application(s), medical questionnaire(s), or amendment(s) that becomes a part of this application(s); and (3) the Part D of the completed Tele-App interview or the Delivery Receipt form is signed by me and the Insured (if different) and dated at delivery. If these conditions are met, the reinstatement is deemed effective on the date of approval.

☐ This application(s) is Cash on Delivery (C.O.D.); and no Conditional Receipt coverage is provided, or

☐ I have paid $ _____ for reinstatement of this Disability Income/$ _____ for reinstatement of this Overhead Expense/$ _____ for reinstatement of this Disability Buy-Out/$ _____ for reinstatement of this Key Person insurance, which is no less than one month's advance premium. If money was paid, I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms, or

If preapproved by Principal Life Insurance Company:

☐ I have signed, dated and submitted to the Company one of the three documents listed below in this box. I have been given the Conditional Receipt. In return I have read, understand, and agree to its terms.

- Payroll Deduction Authorization Form
- Employer Pay Form
- Other form acceptable to the Company

(continued on next page)

Principal Life
Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance
Adjustment or Reinstatement
Application – PART C

Proposed Insured _____ Policy Number (if known) _____

(continued from previous page)

Agreement/Authorization to Obtain and Disclose Information

Limitation of Authority: I understand and agree that no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change, or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on this application(s) and on any medical questionnaire(s) that becomes a part of this application(s) may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).

AUTHORIZATION: I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution, or person having personal information (including physical, mental, drug, or alcohol use history) regarding the named Proposed Insured to provide to the Company, its representatives, or reinsurers, any such data. I authorize the Company to conduct a telephone interview in connection with my application(s) for insurance.

I authorize the Medical Information Bureau, Inc. (MIB, Inc.) to furnish data to the Company or its reinsurers. I authorize Principal Life to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct, or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I have received a copy of the "Notice of Insurance Information Practices," which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc. I agree that this authorization shall be valid for 24 months from the earlier of: (1) the date of this application(s), or (2) the date of my policy. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree that a photocopy of this authorization is as valid as the original. I have received a copy of this authorization.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

Principal Life
Insurance Company
P.O. Box 14455
Des Moines, IA 50306-3455

Disability Insurance
Adjustment or Reinstatement
Conditional Receipt

(In this Conditional Receipt (Receipt), "we", "us", "our", or "the Company" is Principal Life Insurance Company.)

Name of Proposed Insured

Advance payment of: (Disability Income) $ _____ (Overhead Expense) $ _____ (Disability Buy-Out) $ _____ (Key Person) $ _____

has been received this date as a premium deposit with the application(s) bearing the same date as this Receipt.

Agent/Broker/Licensed Representative

Date of Receipt ___ / ___ / _____

Authority:

This Receipt is not a "binder." No agent, broker, licensed representative, medical examiner, or telephone interviewer may accept risks, determine insurability, or bind the Company in any way. No agent, broker, or licensed representative may waive or change any terms of the Receipt, or of the policy(ies) applied for, or any other rights of the Company.

The agent, broker, or licensed representative has **NO AUTHORITY** to accept any premium or to issue this Receipt: 1) if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied; 2) for removal of any extra premium or exclusion rider. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the agent, broker, or licensed representative, has authority to modify any provisions of this Receipt.**

Insurance Provided:

If all of the **Conditions Precedent** set forth in this Receipt are fulfilled exactly, insurance under this Receipt takes effect on the **Start Date**. The Start Date for adjustments and reinstatements is the date upon which all of the adjustment and/or reinstatement application(s) requirements are completed. These application(s) requirements consist of full completion and signing of the application(s) (Parts A and C, if using the telephone application(s) process; Parts A, B, & C, if using the paper application(s) process) and all necessary supplements, and any medical exams and tests required by our published rules.

The insurance provided by this Receipt shall be the lesser of the amount applied for on this application(s) or the amount set forth in the **LIMITATIONS** section of this Receipt, subject to all the **LIMITATIONS** set forth in this Receipt. Any insurance provided by this Receipt ends on the **Stop Date.**

The Stop Date for adjustments is the earliest of:

(a) 75 days after the Start Date;

(b) the date we mail the owner a premium refund and a notice that we will not consider the application(s) on a prepaid basis;

(c) the date we mail the owner a premium refund and a notice that no adjustment will be issued on the application(s);

(d) the date an approved adjustment is presented to the owner (whether or not accepted by the owner).

The Stop Date for reinstatements is the earliest of:

(a) 45 days after the application(s) date;

(b) the date we mail the owner a premium refund and a notice that no reinstatement will be approved on the application(s);

(c) the date the policy(ies) is reinstated.

In determining whether to issue coverage and on what terms, we will consider no changes in the Insured's health or insurability occurring between the Start Date and Stop Date. If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

--CONTINUED--

Conditions Precedent if a premium deposit is submitted with this application(s):

All of the following conditions must be fulfilled exactly. Otherwise there is NO insurance under this Receipt and the Receipt is void:

1. All statements of material fact are included in Part(s) A, B, and C of this application(s), any supplemental form(s) and medical questionnaire(s) that become part of the policy(ies) and such statements are correct, true, and complete.
2. The premium deposit must be paid at the time the application(s) is signed, and this Receipt must be issued at the same time.
3. The premium deposit must be received in our Home Office and must be honored on first presentation for payment.
4. The premium deposit for adjustments must be at least one full month's premium for each adjustment applied for. The premium deposit for reinstatements must be at least three month's premium for each reinstatement applied for.
5. The insured must be insurable on the Start Date. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
   a. For an adjustment, "Insurable" means insurable under our underwriting guidelines and standards in effect as of the date of the adjustment application(s), and:
      (i) the policy(ies) must be in force as of the date of this receipt, and
      (ii) the amounts and benefits applied for can be provided at our standard premium rate with no restrictive riders; or
      (iii) the amounts, benefits and premium can be provided but on a modified basis which may include restrictive riders and/or premium ratings.
   b. For a reinstatement, "Insurable" means insurable under our underwriting guidelines and standards in effect as of the date of the reinstatement application(s), and:
      (i) the amounts and benefits of the policy(ies) can be reinstated without addition of restrictive riders and/or premium ratings, and
      (ii) the insured must be insurable for disability insurance based on the terms of the lapsed policy(ies) on the Start Date.

Conditions Precedent if no premium deposit is submitted with this application(s):

All of the following conditions must be fulfilled exactly. Otherwise there is NO insurance under this Receipt and the Receipt is void:

1. All statements of material fact are included in Part(s) A, B, and C of this application(s), any supplemental form(s) and medical questionnaire(s) that become part of the policy(ies) and such statements are correct, true, and complete.
2. Documentation authorizing payment of premiums, which is acceptable to the Company, must be signed, dated, submitted with the application(s), and this Receipt must be issued at the same time.
3. Documentation authorizing payment of premiums, which is acceptable to the Company, must be received in our Home Office.
4. The insured must be insurable on the Start Date. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability.
   a. For an adjustment, "Insurable" means insurable under our underwriting guidelines and standards in effect as of the date of the adjustment application(s), and:
      (i) the policy(ies) must be in force as of the date of this receipt, and
      (ii) the amounts and benefits applied for can be provided at our standard premium rate with no restrictive riders; or
      (iii) the amounts, benefits and premium can be provided but on a modified basis which may include restrictive riders and/or premium ratings.
   b. For a reinstatement, "Insurable" means insurable under our underwriting guidelines and standards in effect as of the date of the reinstatement application(s), and:
      (i) the amounts and benefits of the policy(ies) can be reinstated without addition of restrictive riders and/or premium ratings, and
      (ii) the insured must be insurable for disability insurance based on the terms of the lapsed policy(ies) on the Start Date.

--CONTINUED--

Limitations:

1. Except as limited by this Receipt, our liability is governed by the terms of the policy(ies), including but not limited to all policy(ies) riders and endorsements.
2. No benefit is payable under this Receipt and this Receipt is void, if there is any incorrect, untrue, incomplete, or omitted statement of material fact in Part A, B, or C of the application(s), any supplemental form, or medical questionnaire(s) that becomes a part of the policy(ies). No knowledge of any fact on the part of any agent, broker, licensed representative, medical examiner, telephone interviewer, or other person shall be considered knowledge of the Company unless such fact is stated in the application(s).
3. There is NO Conditional Receipt coverage before the Start Date.
4. There is NO Conditional Receipt coverage after the Stop Date.
5. There is NO Conditional Receipt coverage if any material misrepresentation exists on the application(s) or examination.
6. There is NO Conditional Receipt coverage for adjustments if less than a full month's premium is paid. There is NO Conditional Receipt coverage for reinstatements if less than three month's premium is paid.
7. a. For an adjustment, limits of coverage under this receipt are the lesser of:
   (i) the amount of insurance applied for, or
   (ii) the modified insurance as determined by 4a(iii) above, or
   (iii) $5,000 per month (Disability Benefit and Social Insurance Substitute Benefit); $5,000 per month (Overhead Expense Benefit); $5,000 per month (Business Loan Protection Benefit); $2,500 per month (Catastrophic Disability Benefit); $2,500 per month and $200,000 Lump Sum (Key Person Benefit); $500,000 (Disability Buy-Out Maximum Aggregate Benefit).

   b. For a reinstatement, limits of coverage under this receipt are the lesser of:
   (i) the amount of the lapsed policy(ies), or
   (ii) $5,000 per month (Disability Benefit and Social Insurance Substitute Benefit); $5,000 per month (Overhead Expense Benefit); $5,000 per month (Business Loan Protection Benefit); $2,500 per month (Catastrophic Disability Benefit); $2,500 per month and $200,000 Lump Sum (Key Person Benefit); $500,000 (Disability Buy-Out Maximum Aggregate Benefit).

Premiums:

If no adjustment is put in force and no benefit is paid or if an adjustment is issued differently than applied for that results in a premium refund, the premium sent with this adjustment application(s) or express premium will be refunded to the premium payer.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PRINCIPAL LIFE INSURANCE COMPANY – DO NOT MAKE CHECKS PAYABLE TO THE AGENT/BROKER/LICENSED REP. OR LEAVE THE PAYEE BLANK.

Principal Financial Group

Principal Life Insurance Company
PO Box 14455
Des Moines, IA 50306-3455

Overhead Expense Application Supplement

1. Personal Information

Proposed Insured	Date of Birth
Name of your business	

2. Indicate the Coverage(s) Applying For

- ☐ **Overhead Expense only** (answer Questions 3-8)
- ☐ **Overhead Expense and Business Loan Protection Rider** (answer Questions 3-9)
- ☐ **Business Loan Protection Rider only** (answer Questions 3, 4, 5 and 9)

3. Overhead Expense

Benefit Amount $ _____

Elimination Period ☐ 30 day ☐ 60 day ☐ 90 day

Maximum Aggregate Benefit Factor ☐ 12 ☐ 18 ☐ 24

You ***MUST*** select **ONE** of the following:

- ☐ Benefit Update (BU) AND Automatic Increase Option (AIO)
- ☐ Benefit Update (BU) only
- ☐ Automatic Increase Option (AIO) only
- ☐ Neither BU nor AIO

Optional Benefit Riders:

- ☐ Residual Disability Benefit
- ☐ Other _____
- ☐ Business Loan Protection (BLP)

BLP Monthly Benefit Amount $ _____ (Round up to nearest dollar)

BLP Elimination Period: ☐ 30 day ☐ 60 day ☐ 90 day ☐ 180 day ☐ 365 day

BLP Termination Date: ____ / _____ (Loan payoff date or earlier selected date. Date must not exceed age 65 policy anniversary)
MM YYYY

Owner (if other than proposed insured) – (Please list owner and have sign this form and Part C).

Name _____ Address _____

City _____ State _____ Zip _____ Owner Taxpayer ID Number _____

Loss Payee (if other than the owner) FOR OVERHEAD EXPENSE ONLY

Name _____ Address _____

City _____ State _____ Zip _____

4. Type of business:

☐ Sole proprietorship ☐ Partnership ☐ C-Corp ☐ S-Corp
☐ Limited Liability Company (LLC) ☐ Other

Principal Financial Group

Principal Life Insurance Company
PO Box 14455
Des Moines, IA 50306-3455

Overhead Expense Application Supplement

Proposed Insured _____ Policy Number (if known) _____

5. Expense Liability and Business Ownership Information

a. Your percent of ownership _____%
b. Your share of overhead expenses _____%
c. Name(s) and ownership percentage of other owners _____

_____

d. If other owners, do they have, or are they applying for Overhead Expense insurance?..... ☐ Yes ☐ No
If No, explain: _____

_____

6. Expense Information

a. LIST YOUR SHARE OF THE CURRENT, AVERAGE MONTHLY OVERHEAD EXPENSES

Rent, OR	$ _____	Electricity, heat, and water	$ _____
Mortgage (interest and principal)	_____	Continued education	_____
Property taxes	_____	Office supplies	_____
Insurance premiums (property, malpractice, fire, liability)	_____	Telephone	_____
Loan payments for furniture and equipment	_____	Subscriptions and membership dues	_____
		Other fixed business expenses, not including employee salaries:	
Accounting, billing, and collection fees	_____	_____	_____
Security and maintenance	_____	_____	_____
		_____	_____

b. TOTAL ELIGIBLE OVERHEAD EXPENSES (Sum of Itemized Expenses above) $ _____

7. Fee For Service Professionals Only (e.g. Doctor, Lawyer, CPA, etc.)

Does the business employ other individuals from your profession? ..... ☐ Yes ☐ No
If Yes, how many? _____

8. List the job title, number and monthly salaries of non income producing employees. Exclude members of your profession:

Job Title	Number of Employees	Combined Monthly Salaries (your share)
_____	_____	$ _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
	Total salaries	$ _____

Principal Financial Group

Principal Life Insurance Company
PO Box 14455
Des Moines, IA 50306-3455

Overhead Expense Application Supplement

Proposed Insured _____ Policy Number (if known) _____

9. Loan Information

a. Purpose of the loan is to purchase: ☐ Building ☐ Equipment ☐ Practice
☐ Other (please specify) _____

b. Loan Number _____

c. Financial Institution/Lender
Name _____
Address _____
Phone Number ( ) _____

d. Monthly Amount of Loan Payment $ _____ Effective Date _____ PayOff Date _____

e. Is the loan obligation shared with any other person? ☐ Yes ☐ No
If yes, Name(s) and percent of loan obligation for each person _____

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

I represent that all the above statements in this application are true and complete to the best of my knowledge and belief. I understand that the statements in this application are a part of any insurance issued.

SIGNATURES (Please do not print name below. **Signatures are required.**)

Proposed Insured **X**	Signed at: City	State	Date / /
Owner (If other than Proposed Insured) **X**	Title (If Corporation, Officer other than Proposed Insured)		Date / /
Witness (Agent/Broker/Licensed Rep.) **X**			Date / /

SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
Company Tracking Number:	*HH777*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
Company Tracking Number:	*HH777*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 10/07/2008

Comments:

We certify that the forms in this submission meet the provision of Rule and Regulation 19 regarding unfair sex discrimination in the sale of insurance, as well as all applicable requirements of the Department.

We have reviewed our issue procedures and assure you that we are in compliance with and provide the Life and Health guaranty notice required by Regulation 49.

A certificate of readability is attached.

We have reviewed our procedures and assure you that we are in compliance with and provide the notice required by Arkansas Code Ann. 23-79-138.

Attachment:

AR Readability.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 10/07/2008

Comments:

New application forms are being submitted under the Form Schedule tab.

Bypassed -Name: Outline of Coverage **Review Status:** Approved-Closed 10/07/2008

Bypass Reason: Not applicable to this Disability Income filing.

Comments:

Attached is the outline of coverage. This form is also included under the Form Schedule tab.

Satisfied -Name: Addendum to issue basis **Review Status:** Approved-Closed 10/07/2008

Comments:

SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
Company Tracking Number:	*HH777*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

Attached is the Addendum to Issue Basis for the underlying policy form.

Attachment:

HH702AR addendum issue basis 8-2008.pdf

SERFF Tracking Number:	*PRLD-125812821*	*State:*	*Arkansas*
Filing Company:	*Principal Life Insurance Company*	*State Tracking Number:*	*40446*
Company Tracking Number:	*HH777*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.005 Business Overhead Expense - Related to marketing with employer or association groups*
Product Name:	*Business Loan Protection Rider*		
Project Name/Number:	*BLPR/HH777*		

Satisfied -Name: Forms being replaced list

Review Status:
Approved-Closed 10/07/2008

Comments:
Attached is a list of forms being replaced.

Attachment:
Forms being replaced list.pdf

ARKANSAS READABILITY CERTIFICATION

PRINCIPAL LIFE INSURANCE COMPANY

This is to certify that the attached forms:

Form No.	Score
HH777	51
AA1751-3	47
AA1700-3	50
AA2150-2	51

has achieved a Flesch Reading Ease Score as noted above and comply with the requirement of Arkansas Statute Annotated 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Date 09/15/2008

Jeff Hostetter
Assistant Director
Product Management

Principal Life Insurance Company
Des Moines, Iowa

Addendum to Description of Policy, Issue Basis and Riders Available
For Overhead Expense Policy Form HH 702 AR et al

New Rider Available

Business Loan Protection Rider – HH 777

This rider is available at issue ages 18 through 60.

This rider provides up to the Business Loan Protection Maximum Monthly Benefit if You have a Continuous Disability that begins on or after the effective date of the rider and while the policy and rider are in force subject to the policy and rider provisions.

This rider terminates on the first of:

1. The Business Loan Protection Termination Date; or
2. The date the Contractual Agreement covered by the rider terminates; or
3. The owner writes a written request to terminate it; or
4. The insured reaches the Age 65 Policy Anniversary; or
5. The policy terminates.

FORM NUMBER	FORM NAME	FORM REPLACED
HH 777	Business Loan Protection Rider	None
JK 36-2	Outline of Coverage	JK 36-1
JK 36 A-2	Outline of Coverage	JK 36 A-1
AA 1751-3*	Disability Insurance Application	AA 1751-2
AA 1700-3*	Disability Insurance Adjustment or Reinstatement App	AA 1700-2
AA 2150-2	Overhead Expense Application Supplement	AA 2150-1

*These applications are used in conjunction with previously approved form AA 1800 (Part B, consisting of pages 4 thru 7 of the application packet) that contains the medical/underwriting questions.